Kansas Department of Health and Environment

Adult Care Home Program

FACT SHEET

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In this issue....

The federal is published by the Kansas Department of Health and Environment.

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L PLEASE ROUTE THIS *Fact Sheet* TO NURSING STAFF AND OTHER INTERESTED PARTIES IN YOUR FACILITY. THIS PUBLICATION MAY BE COPIED OR ACCESSED THROUGH THE INTERNET ADDRESS ABOVE.

The Adult Care Home Program Fact Sheet is a newsletter published by the Kansas Department of Health and Environment and sent quarterly to all nursing facilities, long term care units in hospitals, critical access hospitals, intermediate care facilities for the mentally retarded and nursing facilities for mental health. This newsletter provides important up-to-date information concerning the nursing facility industry.

Physician Services in Nursing Facilities

A committee composed of representatives from the adult care home industry and the Kansas Department of Health and Environment developed guidelines for notification of physicians. The guidelines are not regulations. Nursing facilities, long term care units in hospitals, assisted living/residential care facilities are encouraged to review the guidelines. Facilities are not *required* to adopt the guidelines. The guidelines were developed to serve as a basis for reviewing current facility policy and procedures.

Intermediate care facilities for the mentally retarded are encouraged to review the guidelines. ICF/MR facilities are not required to have a licensed nurse on duty at all times. The clients served are not frail elders. Therefore, if the facility decided to adopt the guidelines there would be the need for modification to reflect the differences in the population served and regulatory requirements.

It was the intent of the committee that the guidelines serve as a spring board for dialog between facility staff and the medical staff serving the residents in the facility. Ensuring appropriate notification of changes in the condition of residents should be the focus of the discussions.

The guidelines are divided into two sections. The first section contains a protocol for notifying physicians. The protocol uses the nursing process and also contains guidance for documentation.

The second section contains parameters for situations in which physician notification should be performed immediately or can be delayed to the next office day. Medical directors and individual physicians may wish to set different parameters.

It must be emphasized that these guidelines are a resource for a facility. It is imperative that each facility review their own protocols and make amendments to those protocols only after discussion with staff and the medical director.

Resident Assessment Instrument

Key Change Procedure

A system has been developed which will allow nursing facilities to correct selected MDS and tracking form items. The Health Care Financing Administration has identified KEY fields which can be corrected without submitting a new assessment. Attached to this issue of the *Fact Sheet* is a copy of the form and instructions for completing the form. This form may be mailed or faxed to Myers and Stauffer. The implementation date for the KEY change procedure will be October 1, 1998. The form and instructions will also be available in the bulletin section of the MDS Welcome Screen on the Intranet at Myers and Stauffer.

MDS Bulletins

The welcome page on the MDS Intranet site has an option entitled "bulletins." Facility staff should check this item frequently for updates related to transmission of the MDS and current information concerning completion of the MDS. This site will allow KDHE to provide facilities timely updates. Facilities are encouraged to download the bulletins and distribute the messages to appropriate staff persons. It is essential that administrators ensure that persons responsible for completing and encoding the MDS have the most current information. This office has received a number of calls from facility staff which could have been answered if the staff had been given a copy of the *Fact Sheet.*

MDS 2.0 Questions and Answers

Attached to this issue of the *Fact Sheet* is a summary of information provided by the Health Care Financing Administration related to Section T. Issues specific to Kansas have been added in italics to the information found on the HCFA Website. In the future, most of the information specific to the MDS will be placed on Myers & Stauffer's Intranet website and NOT printed in the *Fact Sheet.*

Critical Access Hospitals with Swing Beds Required to Perform MDS

This agency was notified in August that the regulations for critical access hospitals include a requirement that a comprehensive assessment using the Resident Assessment Instrument must be completed on all patients admitted to a long term care swing bed. KDHE will be working with the Kansas Hospital Association in development of training programs for staff completing the MDS in Critical Access Hospitals. Critical Access Hospitals are not required to transmit the MDS assessment to the state data base at this time.

Health Occupations Credentialing Program Update

HOC Procedures and Forms Presentation: These presentations were such a hit in July that we decided to do another one! The presentation will cover current use of forms and procedures. They are geared toward present or future INSTRUCTORS, COORDINATORS and SPONSORS. The presentation will be held in Topeka on November 10, 1998 from 1:00-3:00 p.m. at Kaw Area Technical School, 5724 Huntoon, in the Basement Testing Center in A Building. Come and join us!

New Sponsorship Program: The pilot sponsorship program for Nurse Aide, Home Health Aide and Medication Aide training began in 1996 and is being concluded. Sixteen sponsors participated in the pilot.

Since the pilot program showed a savings in time and effort, a new sponsorship program for aide training was introduced August 1, 1998. Applications are now being accepted. The program is very similar to the pilot with some streamlining to reduce the paperwork required for the initial application. Course notification is still required one week ahead of the start of

the course. Although the department originally anticipated charging for this program, no charge will be implemented at this time. For an application to the sponsorship program, call (785) 296-6796.

CNA Curriculum Revision: The CNA curriculum revision committee met July 24, 1998 to determine the revisions needed and assign sections for rewriting. The committee is composed of the following individuals representing the specified organizations: Kansas Advocates for Better Care, Deanne Lenhart, Lawrence; Kansas Health Occupations Advisory Committee, Janet Klasing RN, Wichita; Leanna Meeks RN BSN, Topeka; Kansas Professional Nursing Home Administrator Association, Gayla Messenger RN, Cunningham; Kansas Health Care Association, Vicki Meyer RN C, Washington; Kansas Association of Homes and Services for the Aging, Pat Rupp RN BSN, Moundridge; alternate, Carolyn Trow RN, Wichita. The committee will review the revisions, make changes, and circulate the curriculum to associations, the state board of nursing and other interested individuals to review for major discrepancies and feedback for future revisions. The target date for completion of the curriculum is October 26, 1998.

Nurse Aide/Home Health Aide Exam Dates: The date listed as "*exam date preference*" on the course application is intended as just that - a preference. Inclusion of this date on the course application does not indicate that your students will be guaranteed to test on that date. To decrease confusion, HOC recommends leaving that date blank. Scheduling of students to test is done from the rosters in the order in which they are received by HOC. This means that getting your roster in to HOC on the first date of class and/or three weeks prior to the test date is a very good idea!

Inactive Nurse Aide and Home Health Aides: In order to change the status of an aide on the registry, there are two options. Option 1: Submit a notarized employment verification form to HOC. The form is verified by the employer of the nurse aide where the aide has been actively employed doing nursing or nursing related duties. HOC will change the status on the registry to active for two years from the last verified date of employment. Option 2: If the aide has not worked in nursing or nursing related duties in the past two years, then a notarized skills checklist for employment verification must be submitted. The nurse aide must demonstrate each skill satisfactorily on a resident in order for the aide to be returned to active status on the nurse aide registry. Remember that if a medication aide's nurse aide certificate (CMA) is inactive, then the CMA is not able to administer medications. A medication aide must meet the same work requirements of a nurse aide. Please use one of the two methods above for returning the CNA to active status.

Certification results for FY 1998: HOC certified over 4,400 nurse aides, over 1,060 home health aides and recertified 1,923 medication aides in FY 1998. In addition, there were 23,770 inquiries to the Kansas Nurse Aide Registry.

Licensure results for FY 1998: In FY 1998, HOC renewed over 610 Speech Language Pathologists and Audiologists, over 385 Dietitians, and 356 Adult Care Home Administrators.

HOC Scheduled to Move: HOC will be relocating to the Landon State Office Building. The relocation should be complete between October and November 1998. It is anticipated that phone numbers for HOC will remain the same, but the fax number will not. We anticipate our new address to be: HOC, LSOB Suite 620, 900 SW Jackson St., Topeka, KS 66612. Further information about the change of address will be provided as available. Keep watching our web site for the latest.

HOC on the Web at: www.state.ks.us/kdhe/hoc (Please note the slightly different web address.) Staff have recently been putting more forms and information on our web site. All the forms can be "downloaded" using a free copy of Adobe Acrobat which is available through our web site; just click on "Adobe Acrobat Reader," and it will walk you through the necessary steps.

To view a listing of information available on our web site click on "Information Resources." Currently available are: the new *exam schedule* for nurse aide and home health aides, *application for approval of training course* for aide courses, *instructor application, CNA employment verification Q&A, program application for prior approval of education clock hours* for licensure, the *June 1997 Update* and *May 1998 Update, criminal background check request form* and *criminal background check Q&A*.

The web site also details the purpose and background of HOC, staff members and their phone numbers, prohibited offenses checked under the CBC program and links to other related sites. Keep watching for more helpful information in the near future.

E-Mail: With the advent of the web site, HOC now has e-mail! Please use the following format for any staff member: use

their first initial and first six letters of their last name, i.e., "kpelton" then add "@kdhe.state.ks.us" to that. Staff are being encouraged to use e-mail to communicate. HOC cannot accept any documents requiring a fee or original signature over the Internet.

Operator Courses: We currently have seven approved sponsors for the operator course. Sponsors must be one of the following: long-term care provider organization, community college, area vocational technical school, college or university. This course is designed to train operators of assisted living and residential health care facilities under 61 beds, adult day care, home plus and boarding care homes. If you are needing a course or would like to be a sponsor, please call (785) 296-6796.

Comings and Goings: A new staff member has been hired since the last *Update*. Steve Irwin is the Coordinator of the Criminal Background Check Program. His duties include oversight of daily operations and policy and procedure development for conducting background checks within the established parameters. Pat Dismukes, long-time administrator of the adult care home administrator licensure program and the licensure of Dietitians, Speech-Language Pathologists and Audiologists has retired. Best wishes to Pat in her new-found leisure time.

Just a Reminder: Since Topeka has been assigned the new "785" area code, effective October 1, 1998 "913" will no longer be recognized when dialing Topeka (and the northern half of the state). Only the "785" area code will work when dialing staff at HOC. The "913" area code remains in effect for the Kansas City metro area, Atchison, Leavenworth, Osawatomie and Paola.

Waivers: On June 15, 1998, HOC implemented a new process for issuing a waiver to facilities with a prohibition on nurse aide training and competency evaluation. The waiver allows a nurse aide course to be *held in*, but *not sponsored by* an adult care home with this prohibition. Since its implementation, 17 waivers have been approved. The regulatory prohibition on nurse aide training is found at 42 CFR §483.151(b)(2)(3).

It has been determined that it is not necessary for the facilities to submit documentation of current survey status and whether or not they have been deemed a poor performing facility. (Section B questions 12 &13.) These two items will be verified by Health Occupations Credentialing. The intent of this change is to save time and effort on behalf of applicants submitting documentation for a waiver. For the waiver application packet and educational tool, please call HOC at 785-296-0056.

Criminal Background Checks: The enforcement of KSA 39-970 for licensed adult care homes and KSA 65-5117 for licensed home health agencies went into effect July 1, 1998. Arrangements between the Kansas Department of Health and Environment and the Kansas Bureau of Investigation have been progressing such that the department has received preliminary record checks for nearly 94 percent of the requests that have been sent to the KBI. Of those, approximately nine percent have been noted by the KBI as having a criminal record with that agency. When a record is reviewed for convictions which would prohibit employment under the conditions of the law, a notice is generated to the administrator of the requesting facility. This notice is a simple one-page memorandum which identifies the individual and the facility that submitted the request. The notice is as follows:

> ". . . on this (number) day of (month), 1998, Lesa F. Bray, Director of Health Occupation Credentialing, Kansas Department of Health and Environment, gives notice to the operator of (facility/agency) that the review of the information received from the Kansas Bureau of Investigation has been made and it has been determined that (name), an applicant or employee has been convicted of an offense which prohibits employment in an adult care home or home health agency in the state of Kansas pursuant to Kansas Statutes Annotated 39-970 and Kansas Statutes Annotated 65-5117. This prohibition does not apply to any person who has been employed by an entity continuously since July 1, 1992 . . . "

The notice is sent by regular mail, stamped "confidential" and addressed to "administrator" with the name of the facility and the mailing address. This method is used for at least two significant confidentiality and implementation reasons:

- If the named facility administrator has changed, and that change has not been received by Health Occupations Credentialing, the notice may be abandoned or forwarded, or,
- If the facility administrator is unavailable, the notice may go unopened until the administrator is available. This would unduly delay the facility taking appropriate action.

It is the responsibility of the administrator to take whatever steps are warranted to assure the handling of confidential mail.

Several inquiries have been made of the department concerning acknowledgment when the requests are received. The program administration is investigating a method of providing such notice. Another frequent request is that the department provide notice regardless of the status of the inquiry (submit a report back to the requesting party indicating whether or not a criminal record and/or

prohibitive crime exist) on all requests. Though this may seem helpful and beneficial, there are a number of concerns and legal questions regarding the dissemination of that information by the department. However, the concern is being voiced to upper-level management for direction. It is significant to note:

- ! the criminal background check does not provide complete assurance that the individual does not have a prohibiting conviction since the records received and administered by KBI are subject to the information being sent from the various courts
- ! a "negative" (no record) report is conditional upon the issue cited above, and may change the very next day, therefore it may convey a false security
- ! a determination would need to be made between KBI and KDHE whether the department is authorized to indicate that an individual has a criminal record but nothing that falls within the prohibiting crimes
- ! if the department is authorized to provide the information (that an individual has a criminal history, but nothing prohibiting employment), any employment action or decision may not be protected under the terms of the law

This is a complex and controversial program, and with your patience and mutual perseverence, more clarification will be forthcoming. A full status report will be compiled after the end of the first quarter of the program, anticipated being in October or early November.

Criminal Background Check (CBC) Update: With the program up and running, HOC is currently receiving an average of over 150 requests per day. HOC expects this number to drop slightly after initial compliance, but does anticipate over 38,500 requests annually. To date, HOC has received over 18,300 requests. These requests represent 70% of adult care homes and 50% of home health agencies being in compliance with the July 1, 1998 deadline. For a list of prohibited offenses, contact HOC at (785) 296-0056 or access it through the Internet at: www.state.ks.us/kdhe/hoc/offenses.html.

New Regulation Interpretations

Attached to this *Fact Sheet* are two new regulation interpretations. Regulation Interpretation 98-1 concerns prevention of accidents with hot beverages and 98-2 concerns change in level of care charges. Please insert the new interpretations and table of contents.

RESOURCES FOR QUALITY CARE

- Handwashing and Glove Use in a Long-Term-Care Facility by Betsy Thompson et al. was published in the February 1997 issue of *Infection Control and Hospital Epidemiology*. The results of this study was that gloves were worn in 82% of the interactions when indicated, but changed in only 16% of the time when indicated. The rate at which hands were washed when needed before an interaction was 27%, during an interaction 0%, and after an interaction 63%. Gloves were less likely to be used for caring for residents with gastrostomy tubes compared with other residents. Guidelines for the use of gloves were followed more frequently during wound care than during other activities. Microbial transmission potentially could have occurred in 82% of the observed interactions.

  This study supports the concern of many health care professionals that hand washing is not performed in a consistent manner by facility staff. Ongoing education and monitoring of infection control practices are important essentials in an infection prevention and control system.

ANE ISSUE STATISTICS 6/1/98 to 8/31/98
Complaint Calls Assigned for Investigation

ANE Investigations		Care Issues Investigated	
Total	493	Total	431
June	158	June	150
July	187	July	128
Aug	148	Aug	153

*Licensure Category	Civil Penalties				Correction Orders			
	1998 Quarters							
	1st	2nd	3rd	4th	1st	2nd	3rd	4th
Inadequate or inappropriate hygiene and skin care	8	3			38	36		
Inadequate or unqualified staffing	10	16			35	36		
Inoperable or inaccessible call system	-	-			-	5		
Inappropriate or unauthorized use of restraints	-	1			6	8		
Unsafe medication administration or storage	1	-			10	6		
Inadequate nursing services other skin care	8	6			54	58		
Inadequate or inappropriate asepsis technique	-	-			6	3		
Inadequate or inappropriate dietary/nutritional services	-	-			3	6		
Unsafe storage or hazardous or toxic substances	-	-			1	1		
Failure to maintain equipment	2	-			7	4		
Resident right violations	6	1			25	33		
Unsafe high water temperature	-	-			-	3		
Inadequate hot water	1	-			-	1		
General sanitation and safety	2	-			14	17		
Other (including inappropriate admission)	6	1			18	7		
Inadequate rehabilitation services	-	-			-	-		
Civil Penalties	30	27						
Correction Orders					110	98		
Bans on Admission					2	6		
Denials					0	3		

***A correction order or civil penalty may consist of** multiple issues summarized within the licensure categories above.

MDS Questions and Answers

Text in regular type is from the HCFA web page. Text in italics is annotations made by KDHE staff.

Section T

Q: Can a therapist do an MDS without a physician's order?

A: Therapy services must be ordered by a physician *before a therapist can begin therapy. Therefore, a therapist cannot complete the therapy section of the MDS without first obtaining a physician order for the therapy.*

Q: For which patients do I need to complete Section T?

A: Section T must be completed with every MDS required for Part A Medicare patients.
In Kansas, every MDS completed must include Section T.

Q: Which items of Section T must be done on which assessments?

A: Follow the directions on the MDS exactly. The only items that are not completed for each full assessment are items, T1b, T1c, T1d; these items are to be done only with the *Medicare* 5 day assessment *and a Medicare readmission assessment.*

Q: Should I estimate the days/minutes for the Medicare patient based on 15 days even if I expect him to be discharged earlier than that?

A: Yes. The RUG-III group to which the patient is classified is based on the minutes already received (Section P) and those expected to be provided (Section T). In order to accurately group the patient, the form must be filled out according to the directions. If the patient is discharged before the end of the two weeks, the facility will bill at the RUG-III group to which he classified for only the days he stayed in the nursing home.

Q: If the patient discontinues therapy and is discharged 2 days later, how can I do the Other Medicare Required Assessment that is due 8-10 days after therapy is discontinued?

A: You can't. If the patient leaves the facility, you are not expected to do this assessment. The Other Medicare Required Assessment is a tool to allow the facility to accurately re-classify patients for whom therapy has been discontinued. If the person is still in a *Medicare* Part A stay in the facility at 8 days after therapy was discontinued, it is appropriate to re-assess the person to evaluate whether the progress made during therapy was maintained and it is the first time that an assessment can be done that the look back will not capture any rehabilitation therapy provision.
Continued stay on Part A after therapy has been discontinued must be based on medical necessity. Please review the Skilled Nursing Facility Provider Manual.

Q: Is it true that Medicare Part A patients can be assigned to RUG class Rehabilitation high on the 5 day assessment if the patient has received at least 65 minutes of rehabilitation therapy over the previous 7 days, and in the first 15 days after admission is expected to receive 520 or more minutes of rehabilitation therapy on 8 or more days? Does this principle apply for RUG classes *Rehabilitation medium and Rehabilitation low* with different thresholds.

A: Yes, this is how Sections T and P work together to classify patients to those three rehabilitation sub-categories using the 5 day assessment. The thresholds for the days/minutes are part of the Pseudocode that is posted on our web site as part of the documentation of the Medicare Grouper.

Q: How do you count therapy minutes when a resident is being provided PT and OT at the same time?

A: Counting therapy minutes for recording on the MDS must be based on the patient's time spent in therapy. If the patient is receiving therapy for 30 minutes from two disciplines at the same time, there are only 30 minutes to record; the therapists must agree to split it however is accurate, usually 15 minutes each.

Q: Can a patient classify into the *Rehabilitation ultra high* or *rehabilitation very high* groups based on this 5 day assessment?

A: Yes, it is possible. The only patients who will classify into either of these sub-categories are those for whom a week's worth of minutes at Ultra-High or Very-High level have been provided and recorded in Section P by the assessment reference date of the 5 day MDS. As on all 5 day assessments, Section T must be completed, but the minutes of expected therapy recorded there will not influence the classification of the patient.

Q: Do therapy minutes provided on the day of admission count?

A: Yes, but please put the beneficiary's needs ahead of the urge to rush into treatment. The beneficiary has usually had a very tiring day by the time he reaches the SNF on this first day of admission. There is no need to force a therapy session too early, there are plenty of days to capture therapy minutes.

Q: My facility will enter the PPS October 1, can I begin doing Section T for the Medicare patients I admit beginning in September?

A: Yes, that is a great idea. You will need to complete Section T in order to accurately classify those patients that are still on Medicare Part A stays when your facility enters PPS. Having already performed Section T for those patients will greatly ease your transition into PPS. Follow the directions in Section T exactly, including the items about expected therapy, even though you are not yet being paid under the new system.

Also, we have recently conceived another strategy to ease the transition. For assessments you are doing in September, that you believe may be used as Medicare 5 day assessments during your facility's transition into PPS, code "8" (Other Medicare Required Assessment) in Section AA8b, regardless of the type of assessment, is coded in Section AA8a, even though you are not yet in PPS. This is a method that will enable the standard system at the State and Federal levels to identify the assessment as one for which a Medicare claim may be filed and for which a RUG-III group should be assigned.

! The 5 day assessment for Medicare SNF PPS

This assessment is to have an assessment reference date (Item A3a) of any day 1 through 8 of the Medicare Part A stay. Days 1-5 are optimal but days 6-8 are acceptable, and for some patients will actually be more appropriate. So, assess the patient using one of these first 8 days as the date from which you are viewing the patient.

! Reporting Rehabilitation Therapy Minutes on the MDS

In Section P of the MDS, the clinician records the number of days and minutes of rehabilitative therapy (PT, OT, ST) received by the individual beneficiary during the past 7 days, and in the case of the Medicare 5 day assessment, since admission to the SNF. The rehabilitative therapy time reported on the MDS is a record of the time the patient spent receiving therapy services, not a record of the therapist's time. As stated in the August 1996 publication, "Long Term Care Resident Assessment Instrument Questions and Answers", Version 2.0, the patient's "therapy time starts when he begins the first treatment activity or task and ends when he finishes with the last apparatus and the treatment is ended." Set-up time is included, as is time under the therapist's or therapy assistant's direct supervision.

Whether the time spend evaluating the patient is counted depends on whether it is an initial evaluation or an evaluation performed after the course of therapy has begun. The time it takes to perform an initial evaluation and developing the treatment goals and the plan of care for the patient cannot be counted as minutes of therapy received by the patient. However, reevaluations that are performed once a therapy regimen is underway (e.g., evaluating goal achievement as part of the therapy session) may be counted as minutes of therapy received. This policy was established because we do not wish to provide an incentive to perform initial evaluations for therapy services for patients who have no need of those specialized services. However, we believe that the initial assessment is an appropriate cost of doing business. Therefore, the cost of the initial assessment is included in the payment rates.

Likewise, during the course of treatment, the time it takes for the therapist to perform the required documentation may not be counted as time provided to the beneficiary.

NOTE: The example for counting therapy time on page 3-170 of the Long Term Care Resident Assessment Instrument User's Manual, Version 2.0 is incorrect. CROSS OUT that example. A new example will be included in the revised version.

Facilities should review the information provided at the MDS trainings last spring concerning the recording of therapy time. The handout was insertion for page 3-151.

Reporting minutes of therapy in Section T is somewhat different. Section T must be completed with each Medicare PPS assessment, but in the case of a Medicare 5 day assessment, the clinician captures minutes of therapy that are anticipated for the patient during the first 15 days of his nursing home stay. This makes it possible for the patient to classify into the appropriate RUG-III rehabilitation group based on his anticipated receipt of rehabilitative therapy when the assessment is done during the first few days of the SNF stay and there has not been enough time to provide more than the beginning of a course of rehabilitative therapy. The RUG-III grouper takes into consideration both the days and minutes already received by the patient as reported in Section P and the days and minutes expected to be received in the first 15 days of the stay. The number of days and minutes expected, as reported in section T should include those already received. For example, if the patient received an hour of therapy on both the fourth and fifth days (a Monday and Tuesday) of this SNF stay and the prescribed regimen is for him to receive an hour of therapy daily, Monday through Friday, during his first 2 weeks in the SNF; 2 days and 120 minutes would be reported in Section P, and 10 days and 600 minutes would be reported in Section T. The 10 days and 600 minutes includes the 2 days and 120 minutes already received plus the upcoming 3 days and 180 minutes in the first week and the 5 days and 300 minutes of therapy in the second week.

The directions for completion of Section P instruct the assessor to look back over the "last 7 calender days", counting only post admission days and minutes of therapy, when counting the days and minutes of rehabilitation therapy administered. Seven calender days are, by definition, consecutive days. In the case of a Medicare 5 day assessment, however, the assessor will choose as the assessment reference date (MDS item A3a) any day 1-8 of the stay, and will look back over the prior 7 calender days (or over the days since admission *if* the assessment reference date *is* earlier than day 7) and count the number of days upon which more than 15 minutes of therapy were administered, and will count the number of minutes that were provided to the individual patient during those days. It is irrelevant if there is a break in therapy for a weekend or holiday during that time. For example, if day 5 of the stay is chosen as the assessment reference date, the assessor would look back to admission to count the patient's OT, PT, and ST time. If PT was provided for 50 minutes on both the second and fifth days of the stay, that would be recorded as 2 days of PT and 100 total minutes of PT. The actual time therapy was provided should be recorded. It does NOT have to be expressed in multiple of 15 or 10.

Further clarification of Section T:

1) In order to complete the last part of Section T, item 3, Case Mix Group' put the three character code for the RUG-III group into the first 3 spaces of the 5 space Medicare casemix item and 07' into the last 2 spaces. For example, a patient who classifies into the least intensive Clinically Complex group (CA1) would be coded in item T3 (Medicare casemix) as "CA1*07*". Instructions for completion of the State blocks will be issued to providers by their states.

2) Physical, speech and occupational therapy provided outside the building IS captured in Section T, as long as the staff providing the therapy meet the qualifiers. See SOM Transmittal #272, pp. R64, "The therapy treatment may occur inside or outside the facility."

3) Pay attention to the skip instructions for item T2 *in* italics at the top of the item. Be sure you are using the MDS 2.0, 1/30/98 version.

4) The items at T2a-e capture information based on the same one episode when the resident walked the farthest without sitting down, regardless of the need for assistance to get to a standing position. This episode may be a time during therapy. This observation item captures the single HIGHEST level of independence in the observation period (in contrast to capturing the most assistance needed in the observation period, as in Section G of the MDS).

Since this most independent episode may have occurred in therapy (even if the patient was using parallel bars at the time) or on the nursing unit, the communication between the therapists and nursing staff ON ALL SHIFTS is essential.

5) Section T1b of the MDS, the item in which *expected* therapy is reported, only may be completed for the 5 day Medicare assessment or on a Medicare readmission/return assessment (AA8b=1 or 5).

6) If your MDS automation software (incorrectly) requires that MDS items T1b,c, and d be addressed on Initial Admission Assessment (AA8a=01), then the following work-around can be used until the software is corrected:

Enter “0" at MDS item T1b. This will allow MDS items T1c and d to be skipped. One validation error will occur indicating that T1b should be skipped. This error can be ignored until the software is corrected. Note that *if* this work-around is not used, the facility will receive 3 error messages (one for each MDS item T1b, c, and d).

Adult Care Home Administrator Practice Guideline

Guidelines for Notifying Physicians of Clinical Problems

This guideline was developed as a cooperative effort between representatives from the adult care home industry and the Kansas Department of Health and Environment. Facilities may adopt, amend or choose not to use this document. The document is to be considered to be information, not a regulatory requirement.

Definition of practice area:

Clinical care problems and significant changes in condition of residents must be communicated to the resident's physician, the resident's physician's designee or the facility medical director in a timely, efficient and effective manner.

Scope of the problem:

KAR 28-39-147(g)(1) and 42 CFR 483.10(b)(11) require that the resident's physician be notified whenever there is : an accident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's condition; or a need to alter treatment significantly. In the first six months of 1998, fifteen certified facilities out of 302 were found to be out of compliance with this requirement. The issue is reported as being a much more significant problem than identified by surveys.

Notification Process

Notification of physicians in a timely, efficient, and effective manner can be accomplished when a facility has developed a specific system which is consistently followed by licensed nursing staff. Having a consistent system should reduce the number of times a physician is called and ensure that the physician receives the necessary information to make an informed decision concerning the care and services needed by the resident. Facilities should review the following information and determine whether changes need to be made in the facility's policies.

Assessment

1. Licensed nurses have the responsibility of contacting a physician any time they believe a resident has developed a clinical problem which requires physician intervention.

2. An assessment must be performed by the licensed nurse prior to contacting the physician. The following information should be available and provided to the physician as appropriate.

- Vital signs
- findings from a complete or focused head to toe assessment
- current mental status and whether this is a change
- current diagnoses
- allergies to medications, foods etc.
- current medications
- relevant laboratory work/diagnostic studies
- actions already taken

- presence of advance directives

Planning

1. Before the physician or designee is contacted, the nurse should:

- Gather and organize information concerning the resident.
- Save non immediate items for one call and coordinate calls to a physician with other nurses.
- Anticipate questions the physician may ask and have appropriate information available to provide the answers.

2. If the physician must return your call, be available when the call is returned or provide an alternate nurse with the information to be relayed to the physician.

Implementation

1. Attempts to notify a physician should take place in the following order:

- Attending physician.
- Attending physician's designated alternate
- Medical Director

2. In situations requiring immediate action, contact emergency medical services to request immediate transport to a hospital. Notify attending physician of the transport as soon as possible.

3. The nurse contacting the physician should provide the physician with their name, the name of the facility and the name of the resident. If the physician is an on-call physician, identify the resident's attending physician.

4. Inform the physician of services available in the facility or available via mobile units. Examples:

- Mobile X-ray, pharmacy, EKG and laboratory
- Emergency Medication Kit (list of contents)
- Blood glucose monitoring equipment
- Intravenous therapy availability
- Oxygen, pulse oximeter
- Other

5. The resident's legal representative or interested family member should be notified of a significant change in the resident's status unless the resident has specified otherwise.

6. Outcome evaluation. Monitor and reassess the resident's status and response to interventions. Physician should develop a working diagnosis and guide nursing staff in that to expect, what to monitor, and when to re-contact physician if the resident's progress deviates from the anticipated or expected course.

Documentation

1. Document the following in the resident's clinical record:

- Document assessment findings
- all attempts to contact the physician
- all attempts to notify the family/legal representative
- information provided to the physician
- physician's response
- physician orders
- resident status and response
- information provided to legal representative/interested family and their response

2. If the resident remains in the facility determine if a significant change in condition has occurred. Perform MDS reassessment and amend the care plan as needed.

3. If the physician orders a transfer to another health care facility, complete a transfer form. Send a copy of the most recent history and physical, progress notes, advance directive(s), list of current medications, relevant laboratory results and X-ray reports. Provide any additional information which will facilitate continuity of care.

Physician Notification Parameters

Definitions

1. Immediate notification. A physician should be informed at the time the event occurs directly or via an electronic or telephone call system.

2. Non immediate notification. The attending physician should be informed of the event during normal office hours, and generally no later than the next regular office day. If a non immediate event occurs on a weekend or holiday, licensed nurses must determine if the notification can wait until the next office day or the on call physician notified during day time hours.

Condition	Immediate	Non immediate
Alteration in mental status	Sudden decline in mental status.	Gradual decline in mental status.
Bleeding	Poorly controlled or repeat episode within 24 hours (e.g. prolonged nosebleed; bloody emesis; bloody stools not due to hemorrhoids; profuse vaginal bleeding; grossly bloody urine.	New episode of bleeding where bleeding was controlled with no further episodes; bleeding from hemorrhoids.
Chest pain	New onset; or recurrent which is not relieved in 20 minutes by previously ordered Nitroglycerine x 3; chest pain accompanied by change in vital signs, diaphoresis, nausea and vomiting, or shortness of breath.	Known history of chest pain with increase in frequency of episodes.
Diarrhea	Acute onset of multiple stools with change in vital signs (temp > 101E) and/or altered mental status, etc.	Persistent loose stools with stable vital signs. No signs of dehydration
Edema	Abrupt onset in any limb; abrupt onset with tenderness and redness.	Known history of edema with progressive unilateral or bilateral increase; gradually progressive edema with weight gain.

Condition	Immediate	Non immediate
Emesis	Onset of bloody or coffee ground emesis; repeat episodes, pain, associated with change in vital signs.	Emesis of unknown etiology. Note: Emesis of known etiology need not be reported unless potential for dehydration occurs.
Enteral feeding tube	If removed and unable to immediately replace. Unable to irrigate. Tube is not correctly placed. Unable to determine that tube is correctly placed.	Intolerance to tube feeding; leakage around G-tube stoma site.
Falls	Falls with any suspected serious injury. Obvious deformity of extremities (e.g., shortening of lower extremity with outward rotation); hip pain with palpation or inability to walk; head injury; abnormal neurological status; new onset of confusion; laceration with poorly controlled bleeding; bruising over the rib area.	Increased frequency of falls in a 24-72 hour period. NOTE: Falls without injury do not need physician notification.
Medication errors	Resident is symptomatic due to error; medication has potential for significant side effects; lack of medication has potential for significant harm (e.g. anticonvulsants, anticoagulants, antiarrhythmics, antianginals, and antiglaucoma agents). Resident has a known allergy to the medication.	Wrong drug or dose of drug administered and resident is asymptomatic.

Condition	Immediate	Non immediate
Laboratory Values	Any laboratory value which is significantly out of range of normal unless value is consistently out of range and the physician is aware. **The medical director should develop guidance for nursing staff.**	All other values.
CBC	WBC > 12,000* with change of condition or fever HB: < 8* HCT: < 30* Platelets: < 50,000	WBC: > 10,000 without symptoms or fever
Chemistry	BUN: > 60* Calcium: > 12.5 Potassium: <3.0, > 6.0 Sodium: < 125, > 155 Glucose: > 300 in diabetic with signs and symptoms > 400 in diabetic < 70 in diabetic < 50 in anyone	Glucose: consistently > 200 Glycosated HB: any value Albumin: any value Bilirubin: any value Cholesterol: any value Triglycerides: any value. All values other than those listed in the immediate column must be reported.
Drug levels	Dilantin (phenytoin): > 20* mcg/ml, hold next dose Lanoxin (Digoxin): > 2.2, hold next dose Levels *above* therapeutic range in any drug, hold next dose.*	Any normal value.
Protime	INR: > 6 hold Coumadin PT (in seconds): 3 times control, hold Coumadin|	INR: 3-6 hold Coumadin and notify physician. PT (protime) any value
Urinalysis	WBCs > 10 with symptoms; fever, burning, pain, altered mental status	WBCs < or > 10, no symptoms

Condition	Immediate	Non immediate
Urine culture	> 100,000 colony count with symptoms	> 100,000 colony count, no symptoms
X-ray	New or unsuspected finding, such as fracture or pneumonia	old or long standing finding, not change
Pressure ulcers	Stage III or IV receiving no treatment or new complications	New stage II and any stage when current treatment is not effective.
*Unless values are consistently at this level and the phyisican is aware.		

Condition	Immediate	Non immediate
Seizures	New onset or status epilepticus. > 1 seizure in 24 hours.	One seizure with known history and on anti-seizure medication.
Shortness of breath	Acute onset or with chest pain; change in vital signs; labored breathing; ashen or dusky appearance, cyanosis.	Partial relief with previously ordered treatment (oxygen, inhaler); recurrent episodes but now more frequent.
Skin rash	Significant urticaria with swelling about the face and neck; generalized rash in someone taking a new medication.	Generalized urticaria without symptoms; localized, no other symptoms; recurrent.
Vital Signs	Systolic BP: > 200; < 90 diastolic BP: > 110 resting pulse: > 120; < 55* respiration: > 28*, < 10* oral temp: > 101 rectal temp: > 102	Diastolic BP: routinely > 90 resting pulse: > 110 on repeat exam
Unexplained weight loss		5 % in 30 days; 7.5% in 90 days; > 10% in 180 days
Change in behavioral symptoms	Resident is a danger to themselves or others.	Increased symptoms including wandering; forgetfulness; confusion; agitation.
*Unless values are consistently at this level and the physician is aware.		

FACILITY NAME _____ NUMERIC IDENTIFIER _____

FACILITY ID _____

KEY CHANGE REQUEST

State of Kansas

Complete only one "As Submitted" column must be completed on all requests

Item	MDS Description	As Submitted	Change To
AA6a	Facility State Provider No.		
AA6b	Facility Federal Provider No.		
AA1a	First Name		
AA1b	Middle Initial		
AA1c	Last Name		
AA1d	Name Suffix (Jr/Sr)		
AA3	Birthdate	__ — __ — ____	__ — __ — ____
AA5a	Social Security Number	___ — __ — ____	___ — __ — ____
A3a	Assessment Reference Date	__ — __ — ____	__ — __ — ____
A4a	Date of Reentry	__ — __ — ____	__ — __ — ____
R4	Discharge Date	__ — __ — ____	__ — __ — ____
AA2	Gender	Dash 1. Male 2. Female (circle one)	Dash 1. Male 2. Female (circle one)
AA4	Race/Ethnicity	Dash 1 2 3 4 5 (circle one)	Dash 1 2 3 4 5 (circle one)
AA5b	Medicare Number		
AA7	Medicaid No.		
AB1	Date of Entry	__ — __ — ____	__ — __ — ____
AB2	Admitted From (at entry)	Blank Dash 1 2 3 4 5 6 7 8 (circle one)	Blank Dash 1 2 3 4 5 6 7 8 (circle one)
A4b	Admitted From (at reentry)	1 2 3 4 5 6 7 8 (circle one)	1 2 3 4 5 6 7 8 (circle one)
A6	Medical Record No.		
R2b	Date Assessment Completed	__ — __ — ____	__ — __ — ____
R3a	Discharge Status	Dash 1 2 3 4 5 6 7 8 9 (circle one)	Dash 1 2 3 4 5 6 7 8 9 (circle one)
VB2	RAP Process Completed	__ — __ — ____	__ — __ — ____
VB4	Care Plan Completed	__ — __ — ____	__ — __ — ____

Print name of person completing the request form _____

Signature of person completing the request form _____

Facility phone number _____

Facility Fax number _____

Fax to: **Myers and Stauffer (785) 228-6701**

OR

Mail to: **Myers and Stauffer**
Attn: MDS Help Desk
4123 SW Gage Center Dr., Ste. 200
Topeka, KS 66604-1833

OFFICE USE ONLY Completed_____ Initials_____

KEY CHANGE REQUEST

State of Kansas

Purpose: The Key Change Request form is used to correct certain non-clinical MDS and tracking form item errors for records already submitted to, and accepted into, the state database. The elements listed on the form are KEY fields, as identified by the Health Care Financing Administration (HCFA). If an error was made in a non-KEY field, facilities must follow HCFA's policy for determining the necessity of performing a Significant Correction assessment.

A Key Change Request is a manual correction process, both by the facility staff and the state database administrator. Facilities may not electronically submit a "revision" of an assessment record in order to correct an error. Any records identified as having the same assessment reasons (AA8), assessment date (A3a) and/or effective dates (R2b, A4a, R4) as a previously submitted record are rejected as duplicates.

Implementation Date: The Key Change Request form will be implemented on **October 1, 1998**. It may be utilized only on assessment or tracking form records completed on or after June 22, 1998 which have been accepted by the HCFA system.

Completion Date: Facility staff may complete a Key Change Request form at any time after discovering an error in a KEY field on a record that has been accepted into the state database. HCFA has not defined a time limit on this activity.

INSTRUCTIONS

The Key Change Request form applies to a single assessment or tracking form with a KEY field error. A separate Key Change Request form must be completed for each record to be corrected. Please complete the form using black ink only. Pencil and other ink colors are often very difficult to read, especially when submitted by FAX.

1. At the top of the form, enter the complete **Facility Name** as it is licensed with the State of Kansas.

2. Record the **Facility ID** (or FAC_ID) assigned by the State of Kansas on the next line. This ID begins with an "N" or an "H" and is followed by 6 numbers. As an example "N123456" or "H654321"

3. If applicable, enter the resident's **Numeric Identifier** used within your facility. If used, this identifier should appear at the top right of every MDS 2.0 form completed for that resident.

4. The **"As Submitted"** column is used to record responses in the manner in which they were originally submitted to the state database. The *first* 12 KEY field items in that column identify the appropriate record for the state database administrator.

   In the **"As Submitted"** column, complete each of the *first* 8 KEY field items to identify the proper resident, followed by one of the *next* 3 KEY field items to identify the effective date of the record to be corrected. If the effective date field was not required on this particular record, leave the field blank. For example, if requesting a KEY change for an Annual assessment, the Discharge Date (R4) would be left blank since this field is only completed on a Discharge Tracking Form.

   Complete only the item(s) in the *last* 12 KEY fields of the **"As Submitted"** column that you wish to correct. While many of the *last* 12 KEY fields may have been present in the record, they are not required unless a correction is requested for that field.

5. The **"Change To"** column is used to record the correct value for the KEY field item. Make an entry in this column ONLY if you are requesting a correction for a particular field. You may request that more than one item be corrected for a particular assessment or tracking form on a single Key Change Request form.

6. **Review** the completed information carefully to be certain it is correct. Review your facility procedures or submission software to identify the situation that made the correction request necessary. If possible, put in place procedures to prevent such situations in the future.

7. The person completing the form should then **print** and **sign** their name on the appropriate lines at the bottom of the form. This person should be able to respond to any inquires by the state database administrator concerning the Key Change Request. Record the **facility phone** and **fax** numbers where the person completing the form can be reached.

8. **Submit** the Key Change Request form to Myers and Stauffer LC by fax or by mail using the information provided in the bottom right-hand corner of the form. If submitting by fax, it is not necessary to mail the original document. After the corrections have been made to the state database, the form will be faxed or mailed back to you as confirmation that the changes have been made. This may take several days.

9. **Retain a copy** of the Key Change Request form for your records. This will allow you to trace the error corrections made to the state database. The state database administrator is not responsible for providing additional copies of this form to the facility.